

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11255

CERTIFICATE OF DEATH

48a

Reg. Dist. No. 51

1. PLACE OF DEATH:

County

Calvert

City or town

Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Margaret Bertrude Bowen

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

Robert Bowen

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 32 years

July 26, 1916

8. AGE:

Years

Months

Days

If less than one day

32

3

17

hrs. min.

9. Birthplace

Calvert Co., Md.

(Town, county, and state)

10. Usual occupation

Home

11. Industry or business

MOTHER FATHER

James E. Gibson

Md.

12. Name

Maggie S. Robinson

13. Birthplace

Md.

14. Maiden name

Robert

15. Birthplace

Md.

16. Informant

Robert Bowen

Address

Prince Frederick, Md.

17. Burial

Burial

Date

thereof

200

16, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or church

Auburn M. E.

Location

Barstow, Md.

18. Funeral director

A. A. Harkness & Son

Address

Montgomery, Md.

19. (Date rec'd by registrar)

11-15

19-78

Date

signed

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Calvert

City or town

Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

300

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

219-16-1447

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 13, 1948, at 4 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19...

19...

and that I last saw him alive on

19...

Immediate cause of death

Carcinoma of cervix

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Carcinoma of cervix

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

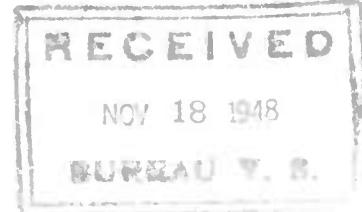
Injured at work?

23. SIGNATURE

Page 2 of 2

M. D. or other

Diana Frederick Date signed



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11256

95C

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County

City or town

Glen
Port Republic

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Margaret Emma Crawford

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Watches Crawford

7. Birth date of deceased (mo., day, yr.)

6. (c) Is alive, give age years

Nov. 26, 1869

8. AGE:

Years

Months

Days

If less than one day

78

11

6

hrs.

min.

9. Birthplace

Calvert Co., Md

(Town, county, and state)

10. Usual occupation

Home

11. Industry or business

MOTHER FATHER

12. Name

Alex Daniels

13. Birthplace

Calvert Co., Md

14. Maiden name

Margaret A. Sedwick

15. Birthplace

Calvert Co., Md

16. Informant

Mrs. Edgar Crawford

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 4, 1948

(month) (day) (year)

Cemetery or

Christ Church

Location

Port Republic, Md

18. Funeral director

A. H. Harkness & Son

Address

Baltimore, Md

19. (Date rec'd by registrar)

11-3 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Calvert

City or town

Port Republic

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

30

MEDICAL CERTIFICATION

20. DATE OF DEATH

October Nov. 19 48 at 1:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1948 1948 to Nov. 2 1948

and that I last saw her alive on Nov. 1 1948

Immediate cause of death

acute Cardiac Demyseard 268

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

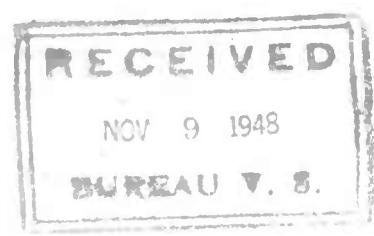
23. SIGNATURE

M. D. or other

Address

Date signed

11/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11257

93d

51

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Calvert

City or town

Prince Frederick, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jessie M. Green.

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

X

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1876

March - 12.

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Domestic.

11. Industry or business

MOTHER FATHER

12. Name

P

13. Birthplace

Md.

14. Maiden name

Ellen Ross.

15. Birthplace

Md.

16. Informant

Oversa Bowen

Address

Prince Frederick, Md.

17. Burial

Date thereof

11-3-48
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Brooks Chapel

Location

Calvert.

18. Funeral director

P. E. Sewell.

Address

Prince Frederick, Md.

19. Date rec'd by registrar

11-2 1948

(Date rec'd by registrar)

H. N. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Calvert

City or town

Prince Frederick.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-1-1948, at 5 A.M.

10

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..., to... Nov 1, 19...

52

and that I last saw h... alive on...

19...

Immediate cause of death - Accidents

DURATION

Central hemiplegia

Due to... Hypertension CVD

Due to...

Other conditions -

(Include pregnancy within 3 months of death)

Major findings or operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

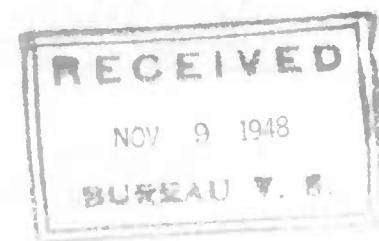
Injured at work?

23. SIGNATURE

G. de Villiers

M. D. or other

St Leonard, No. 11257/48 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 11258

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH:

County *Calvert*
City or town *Prince Frederick*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Calvert Co., Hospital

How long in hospital or institution?

1 week

3. (a) FULL NAME

Joseph C. Hardisty

4. Sex

M	W	W
---	---	---

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Mary Alice Hardisty

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 22, 1878

8. AGE:

Years	Months	Days	If less than one day
70	0	0	hrs. min.

9. Birthplace

Calvert Co., Md.

(Town, county, and state)

10. Usual occupation

Waterman

11. Industry or business

Joseph Hardisty

MOTHER FATHER

*Jnd**Jnd**Sarah Jane Watson**Jnd**Spencer Alderson**Oliver, Md.**Burial*Date thereof *Nov. 24, 1948*
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or cemetery

Location *Oliver, Md.*18. Funeral director *A. A. Wark and Son*Address *Mt. Laurel, Md.*19. *11/24/48* (Date rec'd by registrar) *19* *H. W. Ward* (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Calvert*City or town *Oliver* (If outside city or town limits, write RURAL and give nearest town)Street No. *200* (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-22-4681

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 22, 1948*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *Nov. 13* to *Nov. 22*, 1948and that I last saw him alive on *Nov. 22*, 1948Immediate cause of death *Streuma*Due to *- Acute nephritis**with anasarca*Due to *Hypertension C.O.D.*Other conditions *Severely ill, albuminuria*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

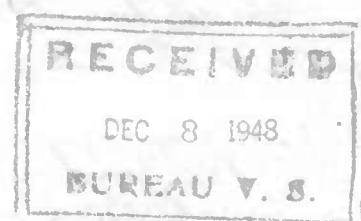
Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury *Injured at work*23. SIGNATURE *J. C. Alderson* M. D. or other *H. W. Ward* Date signed *Nov. 23, 1948*Address *54 Leonard*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11259

Reg. Dist. No. 51

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Calvert

City or town

Susby

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Carl W. Jefferson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

c

x

6. (b) Name of husband or wife

Virginia Jefferson

6. (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.)

Aug 4 - 1923

8. AGE:

Years
25

Months

Days

If less than one day

hrs. min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Columbus Jefferson

MOTHER FATHER

12. Name

Frances Toney

13. Birthplace

md

14. Maiden name

Frances Toney

15. Birthplace

md

16. Informant

Virginia Jefferson

Address

Susby, md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof 11-16-48
(month) (day) (year)

Cemetery or crematory

St. John's

Location

Calvert

18. Funeral director

P.E. Seavell

Address

Prince Frederick, MD

19. (Date rec'd by registrar)

11-16 1948

H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md

County

Calvert

City or town

Susby

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-5-1948, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... fo... 19...

and that I last saw him alive on

19...

Immediate cause of death

Bronch

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of 11/16/48

Where did injury occur? Peters Point Calvert MD

(County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work? yes

Means of injury

23. SIGNATURE

Howard

M. D. or other

Address

Glenwood

Date signed 11/16/48

RECEIVED

NOV 18 1948

BUREAU, U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11260

Reg. Dist. No. 52

CERTIFICATE OF DEATH

58b

1. PLACE OF DEATH:

County.

Calvert

City or town.

Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 hrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

5 hrs

3. (a) FULL NAME

Carol Marcellas

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Mabel Marcellas

7. Birth date of deceased (mo., day, yr.)

June 8, 1910

6. (c) If alive, give age..... years

8. AGE:

38 Years 5 Months

Days

If less than one day

hrs. min.

9. Birthplace

Paris, Calvert Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Theodore Marcellas

12. Name

Theodore Marcellas

13. Birthplace

Md.

14. Maiden name

Cora Cox

15. Birthplace

Md.

16. Informant

Mrs. Carol Marcellas

Address

Paris Md.

17. Burial

Date thereof Nov. 10, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Harmony

Location

Mt. Harmony

18. Funeral director

Wm. L. Hutchins

Address

Owings Md.

19. Date rec'd by registrar

Nov. 10 1948

Date

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.

Md County

City or town.

Paris

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/5 1948 to 11/7 1948 and that I last saw him alive on 11/7 1948

Immediate cause of death

Rheumatic fever

Due to acute endocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

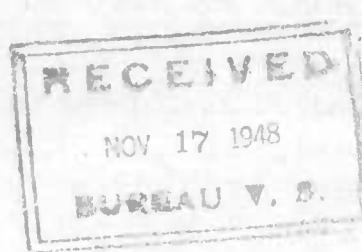
Means of injury Injured at work?

23. SIGNATURE

Howard Owings, Jr. M. D. or other

Address

Owings, Md. Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

11261

Reg. Dist. No. 51

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County CalvertCity or town Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Calvert County HospitalHow long in hospital or institution? 4 hr. & 15 min.

3. (a) FULL NAME

Catherine Rawlings

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Negro

Married

6. (b) Name of husband

George Rawlings

7. Birth date of deceased (mo., day, yr.)

7 Apr. 18956. (c) If alive, give age 61 years

8. AGE:

Years 53

Months

Days

Less than one day
hrs. min. 9. Birthplace Lothian, An Ar. Co., Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Andrew Gray13. Birthplace Md.14. Maiden name Willie Peters15. Birthplace Md16. Informant George RawlingsAddress Chaney, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof 12-2-48
(month) (day) (year)Cemetery or crematory Mt ZionLocation A.A. County18. Funeral director P.E. Sewell

Address

Prince Frederick, Md.19. 12-11948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CalvertCity or town Chaney

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/29/48

19 48 al

4:30pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/28 1948 to 11/29 1948and that I last saw her alive on 11/29 1948

Immediate cause of death

Cerebral accident

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

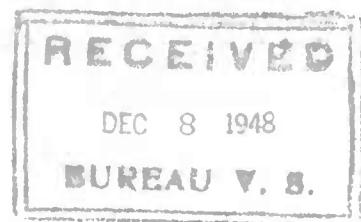
Injured at work?

23. SIGNATURE

M. D. or other11/29/48

Date signed

1895
23
1948
1891



MARGIN RESERVED FOR BINDING

V. S. No. 1.

1. PLACE OF DEATH
 County Calvert
 Village or City Near Owings (No. 36)

N. B. -- Every item of information should be carefully supplied. ACE should be used. EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2 FULL NAME James Allen Tucker		St. _____	Ward) _____	If death occurred in a hospital or institution, give its NAME instead of street and number.)
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>S</u> (Write the word)		
6 DATE OF BIRTH <u>August 12, 1946</u> (Month) (Day) (Year)				
7 AGE <u>2 yrs.</u>	<u>3 mos.</u>	<u>7</u> If LESS than 1 day.....hrs. ds. or.....min. ?		
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
10 NAME OF FATHER <u>Joseph L. Tucker</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
12 MAIDEN NAME OF MOTHER <u>Hilda V. Tucker</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. L. Tucker</u> (Address) <u>Owings, Md</u>				
15 Filed <u>Nov 21 1948</u>	Registrar <u>Grace L. Hutchins</u>			

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 52

MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Nov 20, 1948</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov 19, 1948</u> , to <u>Nov 19, 1948</u> , that I last saw him alive on <u>Nov 19, 1948</u> , and that death occurred on the date stated above, at <u>2 A.M.</u> The CAUSE OF DEATH was as follows:				
<u>Acute Poliomyelitis</u> (Duration) <u>one</u> yrs. <u>one</u> mos. <u>one</u> da. <u>Respiratory Paralysis</u> Contributory Secondary (Duration) <u>one</u> yrs. <u>one</u> mos. <u>one</u> da. (Signed) <u>Compton Wilson</u> M. D. <u>192</u> (Address)				
* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death <u>192</u> yrs. <u>one</u> mos. <u>one</u> da. In the State, <u>192</u> yrs. <u>one</u> mos. <u>one</u> da. Where was disease contracted, if not at place of death? Former or usual residence...				
19 PLACE OF BURIAL OR REMOVAL <u>Mt Harmony</u> DATE OF BURIAL <u>Nov 21, 1948</u> 20 UNDERTAKER <u>W. H. Hutchins</u> ADDRESS <u>Owings</u>				

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc.* of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.